HSDC
Hearing, Speech & Deaf Center

SPEECH, LANGUAGE & LITERACY
ADULT HISTORY FORM

Client's Name_____ Date of Birth_____
Name of person completing this form (if different than client)_____
Client's Occupation_____
Client's Educational Background_____
Client's Primary Language_____
Client's Primary Care Physician_____

1. Please indicate what your specific concern is: (*please check*)

☐ Speech Articulation	☐ Head Injury	☐ Chewing	☐ Voice
☐ Stuttering	☐ Stroke	☐ Swallowing	☐ Other
☐ Expressing Yourself	☐ Problem Solving	☐ Dentition	_____
☐ Understanding Others	☐ Memory Loss	☐ Tongue Thrust	_____
☐ Reading / Writing / Math	☐ Hearing Loss	☐ Head/Trunk Muscle Weakness	

Please describe your concerns_____
_____
_____
_____
_____

2. How long have you had this concern?
_____
_____
_____
_____
_____

3. What questions would you like answered at your appointment?
_____
_____
_____
_____

4. Describe how your specific concerns affect you in your daily life:
_____
_____
_____
_____

5. Have you had any speech therapy or other intervention in the past? If so, when?
_____
_____
_____

What areas of difficulty were addressed in therapy?
_____
_____
_____
_____

Name of therapist_____ Phone number_____

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6. Do any of your family members have a history of speech, language, hearing, or learning difficulties? If so, please describe_____

_____

_____

_____

7. Do you use a nonverbal form of communication? If so, please describe_____

_____

_____

_____

8. Medical History

a. Please indicate whether you have experienced any of the following: (*please check*)

☐ Allergies	☐ Noise Exposure	☐ Enlarged Adenoids
☐ Seizures	☐ Reflux	☐ Ear Infections
☐ Upper Respiratory Infection	☐ Pneumonia	☐ Neurological Problems
☐ Asthma	☐ Dental Problems	

b. Other illnesses

_____

_____

_____

c. Please list any significant injuries you have suffered and the dates on which they occurred:

_____

_____

_____

d. Please list any significant surgeries you have had and the dates on which they occurred:

_____

_____

_____

e. Please list any medications you are currently taking:

_____

_____

_____

Complete the following section only if you are experiencing difficulty with your voice

1. Describe the feelings you are experiencing in your throat: (*please check*)

☐ Hoarseness	☐ Loss of Voice	☐ Pain
☐ Difficulty Swallowing	☐ Difficulty Singing	☐ Strain
☐ Fatigue	☐ Tickling Sensation	☐ Other_____

2. Do you:

Smoke?	☐ Yes	☐ No	How often?_____
Drink caffeine products?	☐ Yes	☐ No	How often?_____
Sing?	☐ Yes	☐ No	How often?_____
Engage in activities that require a loud voice or yelling (e.g. acting, public speaking, teaching, cheering at sporting events)?	☐ Yes	☐ No	List activities_____ _____ _____ _____

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Complete the following section only if you are experiencing difficulties with stuttering

1. Describe the nature of your stuttering (e.g. repeating, getting stuck)._____
_____
_____

2. Do you avoid certain speaking situations? If so, please describe. _____
_____
_____

3. Are there times when your stuttering is better or worse?_____
_____
_____

THANK YOU!